

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-032389

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 4460

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

FILED AUG 28 1963

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Kansas b. COUNTY Johnson	
b. CITY (If outside corporate limits, give TOWNSHIP only) Kansas City		c. CITY OR TOWN Leawood	
Length of stay in: 1b 3 days		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Baptist Memorial Hospital		d. STREET ADDRESS (If outside, give location) 2805 W. 83 St.	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Leo Francis O'Connor		4. DATE OF DEATH Month August Day 8, Year 1963	
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6-25-1900
9. AGE (last birthday) 63		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner		10b. KIND OF BUSINESS OR INDUSTRY Mason-O'Connor Co.	
11. BIRTHPLACE (City and state or country) Detroit, Michigan		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Michael O'Connor		13b. MOTHER'S MAIDEN NAME Unknown	
14. NAME OF HUSBAND OR WIFE Dorothy O'Connor			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. [redacted]	
17. INFORMANT Address Mrs. Dorothy O'Connor 2805 W. 85 St.			
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro Vascular DUE TO (b) Metastasis to brain DUE TO (c) Carcinoma of the lung (bronchial)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a).		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from Sept 1958 8-8-63 and last saw him alive on 8-8-63		Death occurred at 2 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE L. M. Shapiro MD (Degree or title)	22b. ADDRESS 7010 63 - K.C. Mo	22c. DATE SIGNED 8-9-63	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 8-10-1963	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) Kansas City, Missouri (State)
24. FUNERAL DIRECTOR Muehlebach	ADDRESS 6800 Troost	25. DATE RECD. BY LOCAL REG. 8-9-63	26. REGISTRAR'S SIGNATURE R. L. Long

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

L. M. Shapiro MEDICAL CERTIFICATION

11-2570-100

Mr. H. H. H.
No. 101 E. 6th St.
No. 4-2023
after 1.00 P.M.

1800

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Robert L. Linder

Licensed Embalmer No. 5103

P. O. Address K.C. Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.